HEALTH CARE AFFORDABILITY IN WYOMING

Understanding Cost Drivers

June 17, 2026

WYOMING

HEALTH CARE AFFORDABILITY

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Agenda

I. Who is Blue Cross Blue Shield of Wyoming
II. History of Health Insurance in Wyoming
III. What is Health Insurance
IV. Where to Premiums Go?
V. Cost Drivers Affecting Premiums and Health Care Costs.

WHO IS BLUE CROSS BLUE SHIELD OF WYOMING?

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Who is Blue Cross Blue Shield of Wyoming?

Blue Cross Blue Shield of Wyoming (BCBSWY) is a **not-for-profit** health insurer and the only Wyoming-based health insurer headquartered in the state

- Serving Wyoming since 1945
- Over 100,000 members statewide
- Operates eight (8) office across Wyoming
- $1.1 billion in claims paid in 2024

BCBSWY has been an integral part of Wyoming's health care system for 80 years, not separate from it.

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Who is Blue Cross Blue Shield of Wyoming?

Key distinctions of BCBSWY's not-for-profit status:

- **No Shareholder Profit Distribution**
  - No obligation to distribute profits to shareholders
  - Financial results are **reinvested to support members and operations**
- **Single Operational Focus**
  - Operates without obligations to external shareholders
  - Structured to serve our members and mission
- **Use of Financial Resources**
  - Pay claims for BCBSWY members
  - Support member services and operations
  - Reinvest in the organization

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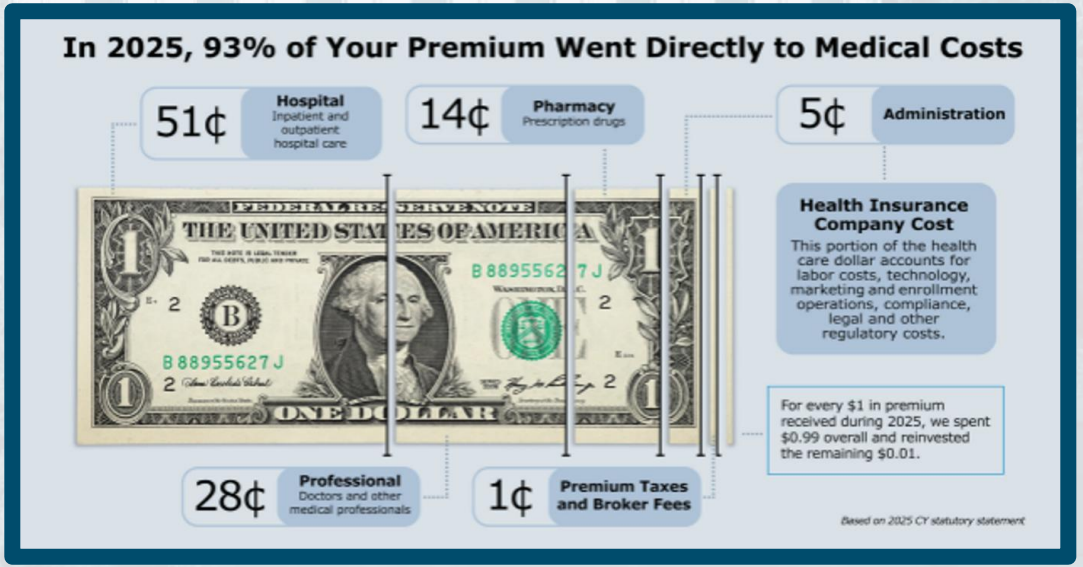
Use of Financial Resources

In 2025, 93% of premiums went directly to medical costs

- Pay claims for BCBSWY members
- Support member services and operations
- Reinvest in the organization.



EVOLUTION OF HEALTH INSURANCE IN WYOMING

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Origins of Health Coverage

Late 1920s: Early health coverage models emerged:

- To provide stable payment to hospitals and physicians during the Great Depression

Early coverage developed into two distinct products nationally:

- Hospital Service Plans (Later Blue Cross)
- Medical Services Plans (Later Blue Shield)

Impact:

1. Helps stabilize financing for hospitals and physicians
2. Establishes the model of third-party payment
3. Reduces price sensitivity for consumers (Moral Hazard)
4. Protects patients from Balance Billing

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1940s: Wartime Policy Drives Employer-Sponsored Coverage

Federal Policy Drivers:

- WWII wage controls limited employers' ability to raise wages
- Federal regulators allowed employers to offer health benefits outside wage limits
- **1943 IRS ruling:** Employer-sponsored health insurance is deemed tax-exempt for employees

Impacts:

- Ties health insurance coverage to employment
- Shifts purchasing decisions from individuals to the employers
- Compensation shifts into benefits rather than wage alone
- Reduces employee visibility of true costs of health care services and coverage
- Establishes expectation of health insurance as a standard employment benefit

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1940s: Events in Wyoming

1945: Wyoming Hospital Service (a nonprofit organization) is founded by the Wyoming Farm Bureau

- Initial offering: prepaid hospital coverage

1947: Rapid growth and adoption

- What is now BCBSWY is approved by the Blue Cross Commission as Wyoming's Blue Cross Plan
- Sponsored by the Wyoming Medical Society, a Blue Shield Plan is established to provide physician services coverage on a nonprofit basis

1948: Enrollment reaches 9,417 members

Impact:

- Establishes nonprofit, community-based coverage
- Expands access to hospital and physician services statewide

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1950s: Events in Wyoming

Federal Policy: 1954 Internal Revenue Code § 106:

- Codifies employer-provided health benefits as tax-exempt income

Continued Growth and Access in Wyoming:

- Wyoming Blue Cross enrollment reaches 65,772 members (22.6% of residents)
- Wyoming Blue Shield enrollment reaches approximately 55,000 members (~20% of residents)
- Approximately 2,000 claims are processed monthly

Impact:

- Growth in both the Blue Cross and Blue Shield plans expands access to healthcare
- Enables greater utilization of health care services.

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Medicare and Medicaid Established

1965: Federal Programs established:

- **Medicaid** is created expanding existing federal support for healthcare services for recipients of Aid to Families with Dependent Children
- **Medicare** is established for people age 65 with two components:
  - Part A (Hospital Services) funded by payroll tax increases
  - Part B (Physician Services) funded by general tax revenues and premiums on seniors

Purpose: Implemented to expand access to healthcare for Americans who faced higher healthcare costs and more limited access to private insurance coverage.

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Medicare (1965-1982)

1965: Federal Programs established:

- **Medicare** is established for people age 65 with two components:
  - Part A (Hospital Services) funded by payroll tax increases
  - Part B (Physician Services) funded by general tax revenues and premiums on seniors
- Medicare mandated institutional providers be reimbursed for the reasonable costs of providing services to beneficiaries

Impact: 1965-1982

- Primary public policy: Expands access to health care services (Lave)
- Hospital reimbursement rapidly increased at annual rates of 20%. (Lave)
- Medicare creates coverage for seniors who lacked access and had high costs
- Introduces government reimbursement benchmarks
- Begins long-term cost shifting dynamics between public and private payors.

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Private Employee Benefits: Studebaker Case (1963)

1963: Studebaker (automaker) faced significant financial deterioration

- Promised pensions to employees but did not fully fund those obligations
- ~4000 employees lose their jobs
  - Most employees receive little to no pension benefits

Federal Response:

- Prompts Congress to take-action for funding standards and oversight of employer-sponsored benefit plans.

Impact:

- Employee Retirement Income Security Act (ERISA) is established.

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Federal Turning Point

1974: Employee Retirement Income Security Act (ERISA)

- Enacted to protect worker's benefits and ensure promised benefits are delivered
- Includes regulation of "employee welfare benefit plans" (health insurance plans)
- Established federal oversight of employer-sponsored benefit plans
- Preempts state regulations for "self-funded" employer health plans

Key Implication for Health Insurance

- Self-funded employer health plans are exempt from state insurance regulations including:
  - Reserve requirements
  - Mandated benefits (in many cases)
  - State premium taxes.

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Federal Turning Point

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- Established federal oversight of employer-sponsored benefit plans
- Preempts state regulations for "self-funded" employer health plans

Impact:

- Expanded federal regulation of employee benefit plans, including health insurance
- Limited state authority over employer-sponsored health plans
- Created a dual regulatory system:
  - Federally regulated self-funded plans
  - State-regulated fully insured plans

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1970s: Wyoming

1974: State of Wyoming awards group health coverage contract to BCBSWY

1976: Rising Health Care Costs

- Rising health care prices drive higher insurance premiums
- Wyoming Blue Cross Plans (hospital) implement a 10-14% rate increase
- Wyoming Blue Shield Plans (physician) implement a 46% increase

1976: Wyoming Hospital Service and Wyoming Medical Service merge into a single corporation, adopting the name Blue Cross Blue Shield of Wyoming.

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Introduction of Managed Care and Selective Contracting

1980s: Rapid price increases drives major payment and delivery reform

- **Medicare**: Transition to prospective payment models
- **Private health insurance**
  - Preferred Provider Organization (PPOs) - preferred provider networks with negotiated pricing
  - Health Maintenance Organizations (HMOs)- limited provider networks, more coordinated care
    - HMO Wyoming is initiated by BCBSWY but stopped after two years
  - Hybrid models are attempted across the nation combining both elements of PPOs and HMOs
  - Represents an early effort to respond to rapid price increases in health care costs and implement downward pressure prices

Impact:

- Introduced selective provider networks through negotiated pricing
- Management of utilization of care begins

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Provider Consolidation Changes Market Structure

Hospitals and physician groups begin consolidating nationwide.

Hospital Market Trends (1990-2000):

- Hospital markets become more concentrated resulting in fewer independent hospitals competing locally (Towns, et al.)
- **More than 90% of concentration** was driven by hospitals merging, being acquired, or joining larger systems. (Towns, et al.)

Physician consolidation: (2000s-2016)

- The share of physician practices owned by a hospital rises by 71.5% (2008-2016)(Graham)
- **By 2016,** 47.2% of private practices were hospital-owned. (Graham).

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Provider Consolidation Changes Market Structure

Impact:

- Selective contracting and managed care led to:
  - Providers consolidating into larger groups and systems seeking stability and stronger negotiations with insurers
  - Emergence of “gate keeping” perception
- Market structure changes
  - Fewer independent providers in local markets
  - Larger, consolidated provider groups shift price negotiation dynamics
  - Market structure became less driven by many small competitors and more by integrated systems

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Wyoming Efforts at Affordability

Wyoming Health Insurance Pool

1990: Established by the Wyoming Legislature, Wyo. Stat. § 26-43-101, to provide health insurance coverage to Wyoming residents who are denied traditional health coverage due to existing medical conditions

Designed as a “last resort” option for people who could not reasonably obtain coverage in the regular insurance market

Eligibility:

- **Must be a Wyoming resident; and**
- **Must provide proof of**
  - That the individual has been denied coverage for health reasons by one insurer; or
  - Have health insurance coverage more restrictive than WHIP’s coverage; or
  - Have health insurance coverage at a rate exceeding WHIP rates.

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Wyoming Health Insurance Pool

1990: Established by the Wyoming Legislature, Wyo. Stat. § 26-43-101, to provide health insurance coverage to Wyoming residents who are denied traditional health coverage due to existing medical conditions

Two Plans:

- **Brown Plan-** Lower coverage, lower costs ($350,000 lifetime benefit cap)
- **Gold Plan-** higher coverage, higher costs ($650,000 lifetime benefit cap)

Coverage: Rates were set at approximately 165% of “normal health insurance premiums”

Delivered Via: State Contract with private insurer (BCBSWY)

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Wyoming Kid Care CHIP

Children's Health Insurance Program (CHIP) was created in 1997

- Wyoming begins participation in 1999
- Program designed to provide children and teens of both working and non-working families with health insurance

Covers children:

- Above Medicaid eligibility
- Up to ~200% of the federal poverty level

Delivered Via: State Contract with private insurer (BCBSWY) until 2022

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Wyoming Healthy Frontiers

Wyoming "Healthy Frontiers" Program (2010-2012) (Administered by BCBSWY)

2010: Governor Dave Freudenthal approves operating plan for "Healthy Frontiers"

- Project was state-funded limited health insurance for working adults
- Funded by $750,000 from the state's Tobacco Settlement Trust Fund

Eligibility:

- Working adults – minimum 20 hours per week
- Not eligible for other coverage programs
- Participants paid $9-$72 per month in premiums

Limited Benefits:

- $500 towards Health Savings Account
- Five primary care visits
- Generic drug coverage and testing
- 90% of hospital visits covered

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Consumer-Directed Health Plans

Mid 2000s: Consumer-directed health plans (HDHPs) often paired with HSAs, emerge:

- Designed to:
  - Lower premiums through higher deductible(short term affordability)
  - Increase consumer engagement in health care decisions
  - Provide protection against major expenses

Impact:

- Improved premium affordability relative to comprehensive plans
- Increased consumer exposure to healthcare costs
  - Greater out of pocket responsibility for the patient
- Influenced utilization patterns in some areas
- Limited impact on overall health care cost growth

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2010: Affordable Care Act (ACA)

Congress passes the ACA in 2010, significantly changing health insurance

- Introducing new federal requirements on how insurance must be priced, structured, and delivered

Key Changes to the Health Insurance Market Place

1) Guaranteed Coverage by Health Insurers

- Coverage available to all individuals regardless of health status
- Insurers cannot deny coverage based on pre-existing conditions
- Individuals may choose to delay purchasing coverage until they anticipate needing care

Impact:

- Expanded access, particularly for individuals with higher health care needs
- Increased participation of higher cost individuals in the risk pool
- Premiums reflect the average cost of broader, more medically diverse population

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2010: Affordable Care Act (ACA) Essential Health Benefits Requirement

2) Key Market Change: Standard Benefits (Essential Health Benefit Requirement)

Individual and small group coverage are required to cover:

- Hospital care
- Doctor visits and outpatient care
- Emergency services
- Prescriptions
- Mental health and substance use treatment
- Maternity and newborn care
- Labo work and testing
- Preventive care
- Rehabilitation services and
- Pediatric dental and vision

Impact:

- Established a high floor product for health insurance coverage
- Restricts Insurers ability to provide more affordable coverage plan through benefit design
- Expands covered services, increasing utilization and overall costs

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2010: Affordable Care Act (ACA)

3) Key Market Change: Premium Rating and Coverage Requirements

- Premiums can no longer be set by health status or medical history
- Premiums must be set based on the overall cost of the insured population
- Elimination of lifetime and annual coverage limitations
- Elimination of individual mandate

Impact:

- Improves affordability for individuals with higher healthcare needs
- Shifts how costs are distributed across the market
- Individual mandate removal increases risk of adverse selection
- **Premiums no longer reflect individual risk**
- **Premiums reflect overall medical costs for the insured population**

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2010: Affordable Care Act (ACA)

4) Key Market Change: Medical Loss Ratio (MLR) Requirements

- The ACA establishes requirements for how premium dollars must be spent
- **Insurers are required to spend:**
  - At least 80% (small and individual market)
  - At least 85% (large group)
  - On medical care and quality improvement
- **The remaining funds may be used for administrative costs, operations and margins**

Impact:

- Aligns premiums with underlying medical costs
- Higher health care costs translate more directly into premiums
- Insurers have limited capacity to absorb cost increases internally
- Increases transparency and consistency in how premiums are used

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Wyoming Events After ACA Implementation

2010: BCBSWY begins implementing provisions of the ACA

2013: BCBSWY is one of two certified carriers to offer coverage through the Federally Facilitated Marketplace

2015: WINHealth, a Wyoming domiciled HMO, is placed into receivership by the Laramie County District Court

2016: Wyoming Insurance Commissioner obtains an order from the District Court declaring WINHealth insolvent

2025:

- Mountain Health Co-Op (11,000) pulls out of the ACA market placing citing highest cost of care in Wyoming
- United pulls out of all but three counties for Medicare advantage

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Wyoming Events After ACA implementation

WINHealth Insolvency largely attributed to four factors:

1)ACA risk-corridor shortfall:

- WINHealth expected a $5.1 million payment from CMS
- CMS paid only 12.6% (~$640,000) of the expected amount

2) Inadequate capital relative to risk exposure

- WINHealth's capital reserves were insufficient for the level of risk assumed
- ACA's Medical Loss Ratio requirements is cited as a primary factor in WINHealth's inability to build or sustain adequate reserves

3) Rapid enrollment growth outpaced existing capital reserves

4) Higher-than-expected claims costs in the ACA individual market

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Recent Wyoming Legislative Trends

2024: Ensuring Transparency in Prior Authorization Act

- Establishes statewide rules for prior authorization
- Requires:
  - Timelines for decisions
  - Transparency in requirements
  - Clinical review standards

Impact:

- Reduces administrative burden for providers and greater financial certainty
- Reduces provider administrative costs
- Increase utilization of medical services
- Improves timeliness of care

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Recent Wyoming Legislative Trends

2024: Gold Carding (Part of Prior Authorization 2024 Law)

- Requires health insurance companies to drop prior authorization requirements for providers with high approval rates

Impact:

- Reduced administrative costs and burden upon providers
- May increase medical utilization and claims
- Limits use of prior authorization as a cost-control tool

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Recent Wyoming Legislative Trends

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Health Insurance Credentialing (HB 82 – 2025)

- Regulates how health insurance companies must credential provider to join their networks
  - Provides timeline requirements for insurers
  - Standardizes the credentialing process
  - Provides oversight to the Department of Insurance

Impact:

- The law is passed to permit greater provider access and participation
- Reduce administrative burden on providers
- Limits insurers flexibility in managing networks

UNDERSTANDING HEALTH INSURANCE

Health Insurance Core Concepts

What is Health Insurance?

Health Insurance is a way for a population to share the costs of medical care

- **Core concept** is to pay a set, predictable amount now, so you don't have to pay a large, unpredictable amount later
- Individuals pay for financial protection
- The value is stability and predictability of costs
- The insurance company must price risk correctly to remain solvent

Key Elements (Traditional Concept of Insurance)

- **A contract** between an individual and an insurance company where:
  - Individual pays a set amount (premium)
  - In exchange, a company agrees to pay for specified losses if they occur

Insurance Risk and Premiums

Risk and premiums are affected by more than just size

Core Concept: Insurance pricing is driven by **risk**, not just the number of people in the pool

Homeowners Insurance Example:

- **Wyoming:** Moderate risk state for homeowners insurance with typical annual premiums of $1,500–$1,999 (Harrison) and about $1,891 annually on average (Paulus)
  - **Key Risk:** Hail, Wind, Growing Wildfire Exposure
- **Florida:** Substantially larger in population, however homeowners pay an average of $10,240 annually (**189% above national average**) (Paulus)
  - **Key Risk:** Wind, Storms, Hurricanes

Insurance Risk and Premiums

Risk and premiums are affected by more than just size

Core Concept: Insurance pricing is driven by risk, not just the number of people in the pool

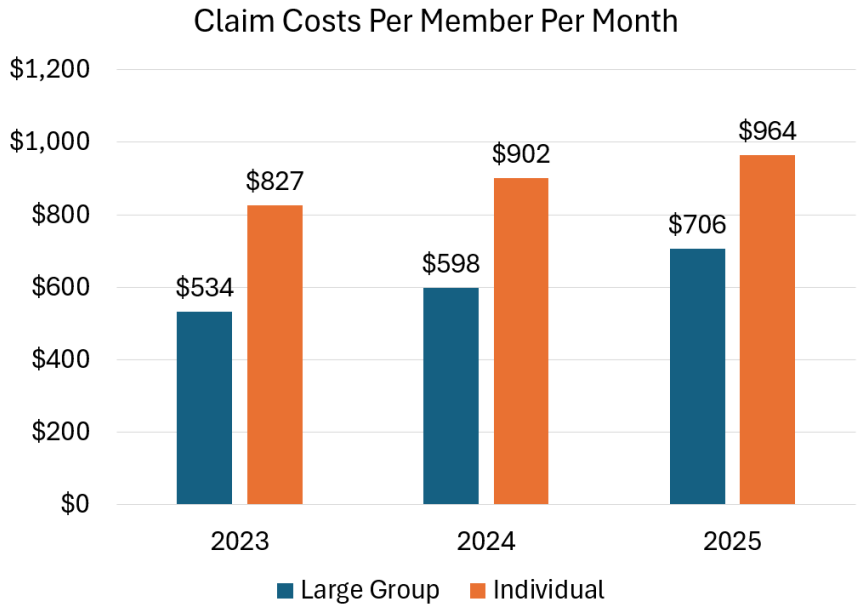
Car Insurance Example:

- **Age 60:** Lower Risk
  - $94 a month
- **Age 16:** Higher Risk
  - $478 a month (Male)
  - $436 a month (Female)

Health Care Affordability

Health Insurance: Risk and premiums are affected by more than just size

- Health care expenditures vary by risk profile, not just group size
- Individual market costs are 40-55% higher per member, despite large enrollment, reflecting higher underlying risk



Health Care Affordability

Health Insurance: Price Sensitivity

Core Idea: People cannot easily reduce use of care when price increases (e.g., people lack sensitivity to price for health care services).

When someone needs immediate care, **they don't have a choice:**
- Emergency Care
- Chronic illness treatment

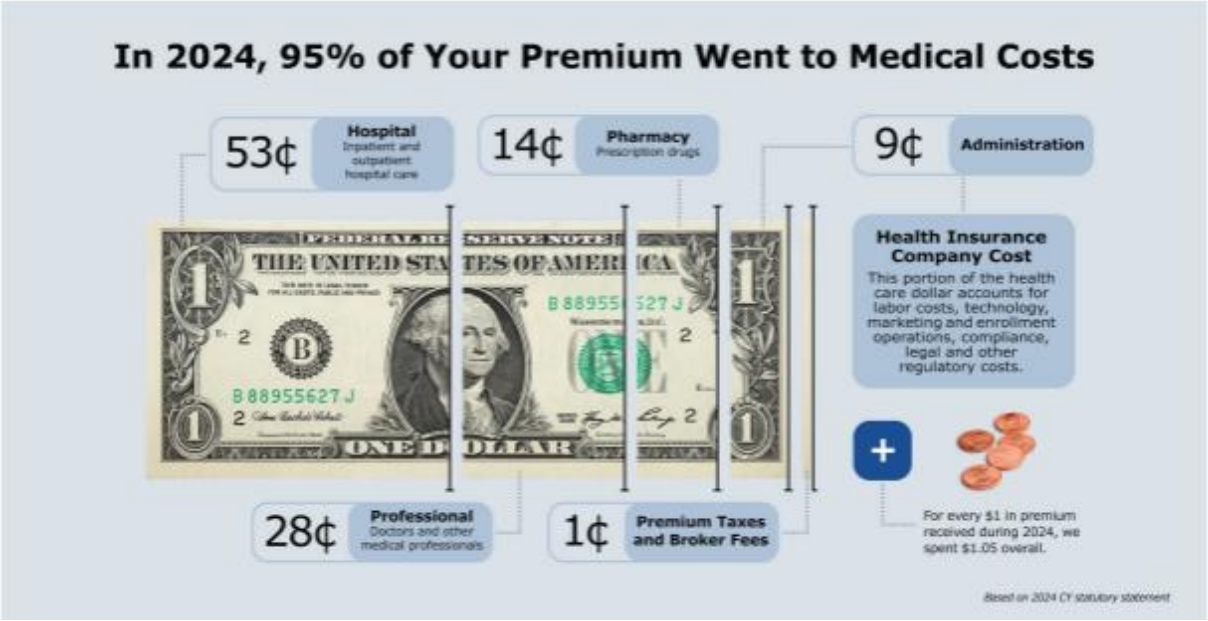
Impact: Higher costs of medical care does not change health care utilization

- **When total healthcare costs increases, premiums must increase to cover those costs**

BCBSWY Premiums

Where do Premium Dollars Go?

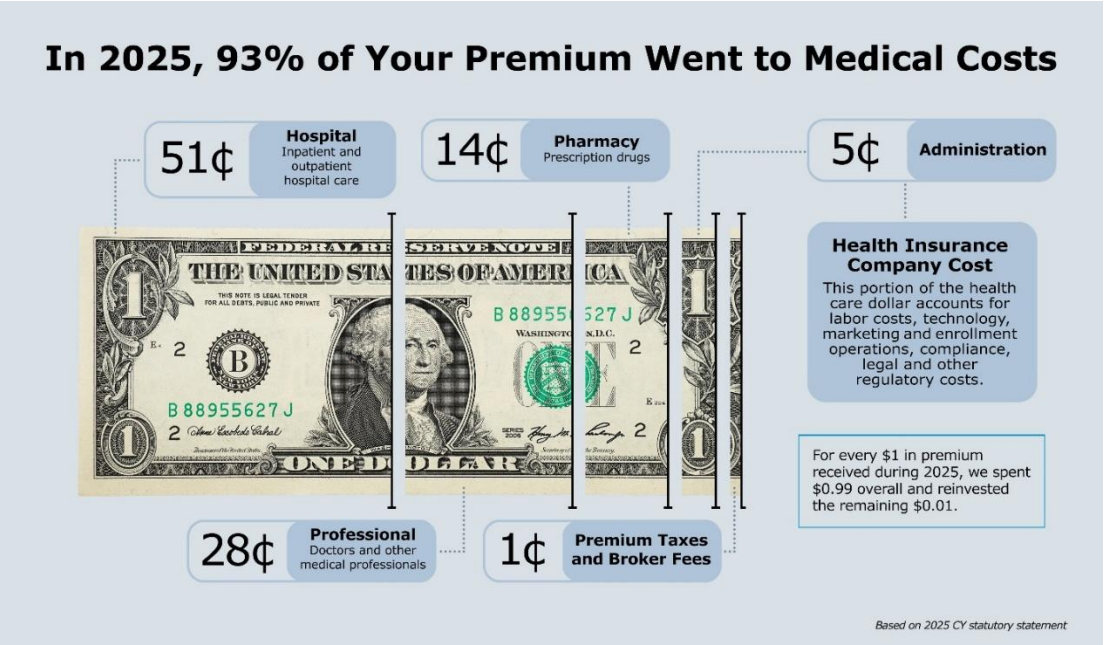
- In 2024, for every $1 in premium received, BCBSWY **spent $1.05 overall**



BCBSWY Premiums

Where do Premium Dollars Go?

- In 2025, for every $1 in premium received, BCBSWY **spent $0.99 overall**



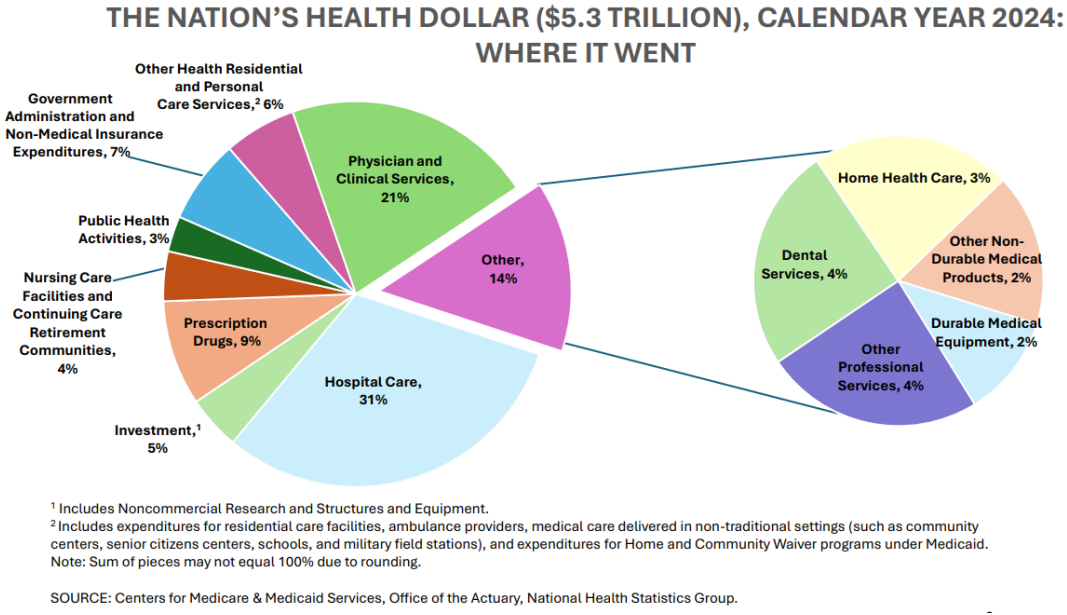
National Spending Distribution

Distribution of Health Care Expenditure (Wyoming vs. Nation).

- Nearly half of all health care spending in Wyoming is driven by hospital services
  - **Hospitals 49%**
  - **Physicians 26%**
  - **Prescriptions 6.8%**
  - **Nursing Homes 4.8%**
  - **Dental 5.1%**
  - **Other 8.1%**

(KFF State Health Facts-2020)

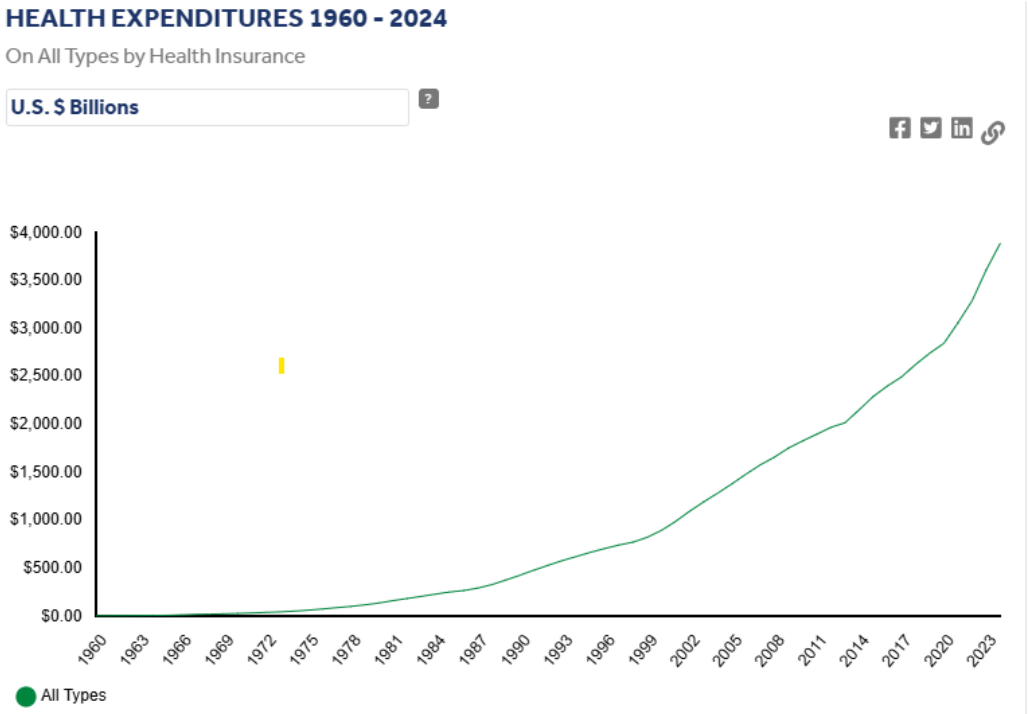
(CMS-*Nation's Health Dollar*)



Rising Health Care Costs

Rising Health Care Costs is Not a New Problem – National Data

Health care spending has risen exponentially over time, despite policy changes

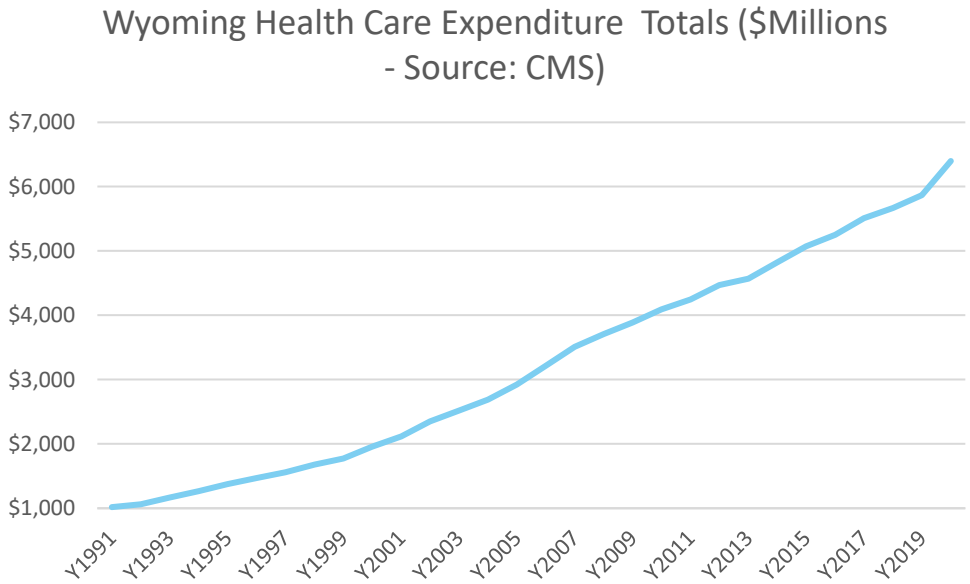


(Peterson-KFF Health System Tracker)

Rising Health Care Costs in Wyoming

Rising Health Care Costs is Not a New Problem – Wyoming Data

- Affordability for health care is not a new problem
- Wyoming health care expenditures have risen an average of 6.5 % each year since 1990. (CMS)
- In 1990, CMS reports Wyoming health care expenditures totaled approximately $1 billion
- **By 2020, CMS reports health care expenditures in Wyoming totaled approximately $6.4 billion (528.5% increase from 1990)**



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